EVIDENCE OF COVERAGE SUBMISSION CHECKSHEET
(Checklist Items based on 2002 Model EOC)

Instructions

"Page #" - Indicate the page number on your EOC in which this information can be found.

- If the particular topic does not apply to your plan (for example, explanation of traveler's benefits or description of the formulary), write "N/A" in this column.
- If the topic is found throughout the document (e.g., member services phone number) write "multiple" in this column

"If not in EOC, where can this be found?" – If you do not include this information in the EOC, indicate what other publication(s) you put it in, e.g., Member Handbook.

H-

M+CO Name *Contract No.*

Material ID No. *No. of Pages*

Section 1 – Telephone/Reference Numbers

	Topic/Requirement	Page #	If not in EOC, where can this be found?
1.	Member Service Department – including TTY and hours of operation		
2.	SHIPs		
3.	PROs		
4.	Medicaid		
5.	Social Security		
6.	Railroad Retirement Board		

Section 2 – Getting started as a member

	Topic/Requirement	Page #	If not in EOC, where can this be found?
1.	Explain that member still has Medicare as a member of your plan		
2.	Copy and explanation of use of Member Card – 422.111(b)(2)		
3.	Member rights – 422.111(f)(3)		
4.	Member responsibilities– 422.111(b)(2)		

Section 3 – Getting the care you need, including some rules you must follow

	Topic/Requirement	Page #	If not in EOC, where can this be found?
1.	Service area listing – 422.111(b)(1)		
2.	Explain difference between "plan" and "non-plan" providers - 422.111(b)(2)		
3.	Define PCP, explain how to pick a PCP and how to get care from a PCP - 422.111(b)(2), Chapter 3 section 30.2.1		Must be in the EOC (does not preclude MCO from including in other publications).
4.	Lock-in language - 422.111(b)(2), Chapter 3 section 30.2.1		
5.	Explain rules for getting specialty care - 422.111(b)(2), Chapter 3 section 30.2.1		
6.	Explain rules for referrals for follow-up specialty care – Chapter 3, section 30.2.1		
7.	Explain/define any self referral services - 422.111(b)(2)		
8.	Explain how to change PCPs - 422.111(b)(2)		
9.	Explain how to get care out of the service area (traveler's benefits) - 422.111(b)(4)		

Section 4 – Getting care if you have an emergency or an urgent need for care

	Topic/Requirement	Page #	If not in EOC, where can this be found?
1.	Rules for getting emergency care - 422.111(b)(5)(i), Chapter 3 section 30.2.1		Must be in the EOC (does not preclude MCO from including in other publications).
2.	Definition of emergency medical condition and emergency services - 422.111(b)(5)(i)		
3.	Explain that you do not need prior authorization for emergency care - 422.111(b)(5)(ii)		
4.	Coverage of post-stabilization services 422.111(b)(5)(iv)		
5.	Rules for getting urgently needed care when in the service area - 422.111(b)(5)(i) and (ii), Chapter 3 section 30.2.1		Must be in the EOC (does not preclude MCO from including in other publications).
6.	Rules for getting urgently needed care when out of the service area - 422.111(b)(4), Chapter 3 section 30.2.1		
7.	Definition of urgently needed services - 422.111(b)(5)(i)		
8.	Member can call 911 for assistance – 422.111(b)(5)(iii)		
9.	Coverage for renal dialysis when member temporarily out of area - 422.111(b)(4), Chapter 3 section 30.2.1		Must be in the EOC (does not preclude MCO from including in other publications).

Section 5 – Your coverage (schedule of medical benefits)

	Topic/Requirement	Page #	If not in EOC, where can this be found?
1.	Define covered services – 422.111(b)(2)		
2.	Explain that benefits can only be enhanced mid-year – 422.111(b)(2)		
3.	List of covered benefits, to include the following as appropriate: - 422.111(b)(2)		
	Outpatient physician services		
	Outpatient mental health care		
	Outpatient substance abuse		
	Outpatient surgical services		
	Emergency Services		
	Urgently needed services		

	Ambulance transportation		
	DME and related supplies		
	Prosthetic devices		
	Outpatient diagnostic and therapeutic services and supplies		
	Chiropractic services		
	Podiatry services		
	Outpatient rehabilitation services		
	Hospital inpatient care		
	Inpatient mental health care		
	Inpatient services when the stay is not/no longer covered		
	Skilled nursing facility care		
	Home health care		
	Hospice care		
	Preventive Care Services (mammography, pap tests, prostate cancer screening, immunizations)		
	Bone Mass Measurements		
	Colorectal screening		
	Diabetes monitoring		
	Medical Nutrition Therapy		
	Blood		
	Drugs & biologicals		
	Baseline health assessment		
	Hearing services		
	Vision care		
	Health education		
	Health promotion		
	Dental services		
4.	Describe optional supplemental benefits 422.111(b)(6)		
5.	How to purchase optional supplemental benefits 422.111(b)(6)		
6.	How to discontinue optional supplemental coverage 422.111(b)(6)		

Section 6 – Using your coverage for prescription medicines - 422.111(b)(2)

	Topic/Requirement	**Page #**	**If not in EOC, where can this be found?**
1.	List additional premium for prescription drug benefit		
2.	Explain how benefit works (copayments, generic vs. brand name drugs)		
3.	Define "formulary" (Chapter 3, section 40.4)		Must be in the EOC (does not preclude MCO from including in other publications).
4.	Explain that the formulary (or drugs on a preferred list) may change during the contract year (Chapter 3, section 40.4)		
5.	Provide an estimate of how often the MCO reviews the formulary contents and makes changes based on the review (Chapter 3, section 40.4)		
6.	Describe any process a provider may use to obtain authorization for a non-formulary or non-preferred list drug to be furnished (Chapter 3, section 40.4)		
7.	Explain that members can use the grievance process for complaints about the formulary or its administration (Chapter 3, section 40.4)		
8.	Explain what benefit maximum is and how it works		
9.	Describe how to fill prescriptions (retail pharmacies, mail order, etc.)		

Section 7 – Using your coverage for hospital care, care in a SNF, and other services - 422.111(b)(2)

	Topic/Requirement	Page #	If not in EOC, where can this be found?
1.	Describe inpatient hospital service coverage, including when the stay is not covered		
2.	Rules for coverage that begins during an inpatient hospital stay		
3.	Describe SNF coverage		
4.	Describe home health care coverage		
5.	Describe hospice coverage		
6.	Describe coverage for organ transplants, clinical trials, RNHCI services		

Section 8 – Medical care and services that are not covered - 422.111(b)(2)

	Topic/Requirement	Page #	If not in EOC, where can this be found?
1.	List services/care that are not covered		

Section 9 - What you must pay for your Medicare health plan coverage and for the care you receive

	Topic/Requirement	Page #	If not in EOC, where can this be found?
1.	Summary of the member's financial obligations - 422.111(b)(2)		
2.	Definition of plan premium - 422.111(b)(2)		
3.	Explanation of how to pay premium - 422.111(b)(2)		
4.	Explanation of what happens when premiums are not paid - 422.111(b)(10)		
5.	Explain that premiums cannot be raised mid-year – 422.111(b)(2)		
6.	Definitions of Medicare premiums - 422.111(b)(2)		
7.	Definitions of copayment, coinsurance, deductible - 422.111(b)(2)		
8.	Explain coordination of benefits - why benefits need to be coordinated, who pays first		
9.	How MCO pays providers		
10.	Explain what to do if the member pays for emergency care, or is billed for services – 422.111(b)(7)		

Section 10 and Appendix B – Appeals and Grievances: What to do if you have concerns or complaints - 422.111(b)(8)

	Topic/Requirement	Page #	If not in EOC, where can this be found?
1.	Explain process for asking for an initial decision, explanation of fast decisions, timeframes for process		
2.	Explain step-by-step process for appealing coverage decisions (first level appeals) – how to file, when to file, explanation of fast appeals, timeframes for appeals process		
3.	Explain CHDR appeals process		
4.	Explain ALJ appeals process		
5.	Explain appeals process at Department Appeals Board level		
6.	Explain process when appeal goes to Federal Court		
7.	Explain the *Important Message from Medicare* – purpose and when received		
8.	Define Peer Review Organization, how to ask for a second opinion on a discharge, and timeline for decisions		
9.	Explain grievance process		

Section 11 – Disenrollment: leaving (plan), and your choices for continuing Medicare after you leave - 422.111(b)(10)

	Topic/Requirement	Page #	If not in EOC, where can this be found?
1.	Explain need to stay with plan providers until disenrollment date		
2.	Explain when and how often beneficiaries can disenroll/switch plans		
3.	Explain how to disenroll to Original Medicare		
4.	Explain how to switch to a different M+C plan or PFFS plan		
5.	Explain what happens when plan non-renews/leaves program		
6.	Explain when M+CO must disenroll member (e.g., moving out of service area)		

Appendix A – Reference List

	Topic/Requirement	Page #	If not in EOC, where can this be found?
1.	Definition of "M+C organization"		
2.	Definition of "M+C plan"		
3.	Definition of "Service area" 422.111(b)(1)		
4.	Definition of "Emergency services" and "Emergency medical condition" 422.111(b)(5)(i)		
5.	Definition of "Urgently needed services" 422.111(b)(5)(i)		
6.	Definition of "Lock-in" 422.111(b)(2)		
7.	Definition of "Prior authorization" 422.111(b)(7)		

Appendix B - Appeals and Grievances: What to do if you have concerns or complaints

(See Section 10)

Appendix C – Legal Notices

	Topic/Requirement	Page #	If not in EOC, where can this be found?
1.	Notice about governing law		
2.	Notice about non-discrimination – 422.111(f)(3)		

Appendix D – Advance Directives - 422.128(b)(1)

	Topic/Requirement	Page #	If not in EOC, where can this be found?
1.	Define "Advance directive"		
2.	Explain how to obtain an Advance Directive		
3.	Explain what to do with the Advance Directive		